Physicians Fee Schedule Key

This file is available as a printable report or a tab-delimited text file. The elements and values are as follows:

HCPCS: CPT- 4 or HCPCS Procedure Code

Note: Special billing information applies to the code

- **A**: Professional and technical components are each 50% of the state max. Number of tests performed in a single calendar day should be billed using the days/units field; quantities greater than 5 must be accompanied by supporting documentation.
- **B**: Professional and technical components are each 50% of the state max.
- **C**: Professional and technical components split, but at a rate other than 50%
- **D**: Code is billable by encounter rate clinics only.
- **E**: Vaccine is available through the Vaccines For Children (VFC) program; the department reimburses for the administration of the vaccine only
- **F**: Vaccine is not available through the VFC; the department reimburses for the vaccine when it is medically necessary
- **G**: Vaccine is available for children, but not adults through the VFC; the department reimburses for the administration (as shown in the Unit Price column) for children, and for adults (as shown in the State Max. column) when medically necessary.
- **H**: CLIA "A" rate for the full test
- **I:** CLIA "W" rate for the waived test
- **J**: Covered only for blood lead draws; must be billed with the U1 modifier
- **K**: Prior approval required

Prog Cov: Program coverage
02 Title XIX coverage only (limited Transitional Assistance coverage)
04 Medicaid-covered services
09 QMB (Qualified Medicare Beneficiary) coverage only – for clients eligible or Medicare, but not Medicaid

HP: Hand priced indicator - "Y" indicates the procedure code is "hand-priced". When HP is blank, the maximum reimbursement rate is located in the State Max. column.

Drug Ind.: Drug Indicator – identifies drug codes.

APL: Ambulatory Procedures Listing – "Y" indicates that the procedure is on the APL listing. Hospitals that bill an APL code fee-for-service will receive a C95 rejection.

M1 (26): Modifier 1 (26) – Rates identified in this field are those paid for the professional component of the code.

M2 (TC): Modifier 2 (TC) – Rates identified in this field are those paid for the technical component of the code.

M3: Modifier 3 – this column is reserved for future use.

Unit Price: Price for each unit when quantities are billed.

Max. Qty.: Maximum Quantity - indicates the maximum quantity allowed to be billed for the code.

State Max: State Maximum - the maximum allowable reimbursement (reflects combined professional & technical components where applicable).

Surg. Add-on: Surgical Add-on – when the procedure is performed in the physician's office this amount is paid in addition to the amount in the State Max. column for the use of surgical instruments/supplies.

If you experience any problems with the files or have questions, please contact the Bureau of Comprehensive Health Service at (877) 782-5565 or e-mail us at hfswebmaster@idpa.state.il.us .